N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Dallas

Township Wilson Registration District No. 247 File No. 24193

or

Village ~~Long Lane~~ Primary Registration District No. 5343 Registered No. 13

or

City ..... (NO. ..... St. ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Erhart Warner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH January (Month) 8 (Day), 1842 (Year)

7 AGE 77 yrs. 10 mos. 17 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed Warner

(Address) Buffalo, Mo.

15

Filed Aug 10 1920 L. L. Talbot Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 25 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 19, 1920, to July 25, 1920, that I last saw him alive on July 24, 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis (Chronic interstitial).

120

(Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prostatitis (chronic)

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

7-24-, 1920 (Address) Buffalo Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL New Liberty Cemetery DATE OF BURIAL 7/26, 1920

20 UNDERTAKER C. E. Routh ADDRESS Buffalo, Mo.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

6 DATE OF BIRTH

..... 1.....
(Month) (Day) (Year)

7 AGE .....yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from .....191....., to .....191.....

that I last saw h.....alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. ..... mos. ..... ds. In the State .....yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS